Jones
THERAPY SERVICES

Feeding History Questionnaire

Today's Date: _____

Child's Name: _____ **Gender:** M F

Date of Birth: _____ **Chronological Age:** _____

Current weight and height: _____

Informant's Name: _____

Evaluating Clinician: _____

1. What concerns do you have about your child's eating that you would like help with at this visit? _____

   _____

2. What do you hope to gain from this appointment? _____

   _____

Medical History

1. Does your child have any medical diagnoses: _____

   _____

2. Does your child have any allergies? Yes No
   Please indicate allergies:
   Food: _____

   Medication: _____

   Contact: _____

3. Was child born at full term (37-40+ weeks)? Yes No If no, how many weeks? _____

4. How much did the child weigh? _____

5. Did the mother have any complications during this pregnancy and/or delivery? If yes, please describe:

_____

_____

6. Was your child ever hospitalized or had surgery? _____

_____

7. Medical tests/procedures been done? Ex: swallow study, upper GI, allergy testing, tonsils/adenoids removed, MRI, etc.): _____

_____

8. List of Doctors: _____

_____

9. Note any current medications and dosages: _____

10. Has your child had a history of reflux, constipation or diarrhea? If yes, please describe _____

_____

Feeding History

1. Was your child breast-fed or bottle-fed? _____
   If breast-fed, how long did your child receive breast milk? _____

2. Was your child given any formulas? If so, what brand/kind: _____

3. Did he/she have any difficulties with breast-feeding or bottle? Yes No
   If yes, please describe: _____

4. At what age did your child begin to eat:
   Purees/baby food? _____ Mashed food? _____ Soft table foods? _____

5. At what age did your child start using a:
   Bottle? _____ Cup? _____ Straw? _____

6. At what age did your child's eating first become a concern? _____

7. Was feeding interrupted at any time in the child's history? Yes No

   For how long? _____

For what reason? _____

Current Feeding

1. Does the child feed self? Use fingers, spoon, fork, etc.? _____

   _____

2. What liquids does the child drink? How much per day? _____

   _____

3. Does your child have any physical pain while (associated with) eating or drinking? Yes No
   If yes, please describe pain level: _____

4. Oral Motor Function:

Does your child drool?	Yes	No
Can your child keep his or her mouth closed?	Yes	No
Does your child have a tongue thrust or poor tongue mobility?	Yes	No
Does your child have problems with sucking?	Yes	No
Does your child choke or gag often?	Yes	No
Can your child bite off pieces of food voluntarily?	Yes	No
Does your child have problems chewing?	Yes	No
Is your child hypersensitive to food textures or temperature?	Yes	No

5. Does your child have any of the following symptoms when eating or drinking?

- ☐ Gagging
- ☐ Choking
- ☐ Vomiting
- ☐ Limited volume/not eating enough
- ☐ Eats a limited variety of food/selective
- ☐ Difficulty swallowing
- ☐ Slow weight gain
- ☐ Refuses to swallow/ holds food in mouth
- ☐ Refuses to eat
- ☐ Difficulty progressing table food
- ☐ Other (specify): _____

Please describe: _____

6. What strategies have you tried to deal with your child's eating problems?

- ☐ Distraction during meals
- ☐ Forcing
- ☐ Skipping meals
- ☐ Allowing child to drink more fluids
- ☐ Rewards
- ☐ Giving preferred foods

☐ Feeding child upon request ☐ Punishment

☐ Coaxing ☐ High calories

☐ Supplements/formula ☐ Other (specify) _____

Please describe: _____

_____

Tube Feeding

1. Does your child us a feeding tube? Yes No If yes, what type (NG, Gtube, G-J, etc.)? _____
2. Type of Formula used: _____
3. Schedule: _____

   _____
4. Provider who tells you what/how much to give through the tube: _____

Eating Environment

1. Where does the child usually sit to eat? _____
2. With who does the child usually eat and drink? Who feeds them? _____
3. How is the child fed? _____
4. Feeding Schedule (Please note this section may be skipped if you have turned in the 3-day diet assessment)

Meal	Typical Time of Meal
Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Snack	